



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

HCAA Medical Group

Respondent Name

Texas Council Risk Management

MFDR Tracking Number

M4-16-1548-01

Carrier's Austin Representative

Box Number 43

MFDR Date Received

February 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The bill attached has been by York Risk with no valid explanation."

Amount in Dispute: \$99.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on February 15, 2016. 28 Texas Administrative Code 133.307 (d)(1) states, "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." As no response was received, this dispute will be based on available information."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 15, 2015	97001-GP59, G8984-GPCM, G8935-GPC1	\$99.79	\$99.79

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers' compensation jurisdictional fee schedule adjustment.
 - 246 – This non-payable code is for required reporting only.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The services in dispute are related to physical therapy services. The carrier indicates adjustment/reason code P12 – "Workers compensation jurisdictional fee schedule adjustment." However, review of the submitted explanation of benefits dated January 22, 2016 shows not payment was made. The services in dispute will be reviewed per applicable rules and fee guidelines.
2. 28 Texas Administrative Code §134.203 (c) states,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

- (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The maximum allowable reimbursement will be calculated as follows:

Date of service	Submitted Code	Submitted Charge	Allowable	MAR (DWC Conversion Factor/Medicare Conversion Factor) x allowable = TX FEE MAR
October 15, 2015	97001	\$99.79	\$73.06	$56.2/35.7547 \times \$73.06 = \114.84
October 15, 2015	G8984	.01	0.00	Not separately payable
October 15, 2015	G8985	.01	0.00	Not separately payable
			Total	\$114.84

3. The maximum allowable reimbursement is \$114.84. The requestor is seeking \$99.79. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$99.79.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$99.79 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

March 24, 2016
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.